County Medical Services Program

Newsletter

Prepared by: AmeriChoice

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Asthma

Your asthma patients are probably asking you if they need to take their medicines anymore because they heard on the news that asthma patients did not need to take daily asthma medicines to control their disease. That is pretty much what I heard on the local news about 4 days before I received the NEJM. So what is the real scoop?

In the article by Boushey, et al. the first element to note was the exclusion criteria- cigarette smoking, URI or use of steroids in the previous six weeks and hospitalization or two or more ER visits for asthma in the previous year.

Treatment protocol was double-blinded with each group taking a pill and an inhaler. One group received oral zafirkulast and inhaled placebo; the second, oral placebo and inhaled budesonide; and the third, oral and inhaled placebo. All were counseled to take open label budesonide or prednisone for exacerbations.

The most touted point of the study is that while the two "treatment groups" were more than 90% compliant with their medications, the "placebo group" took only ½ week of medication during the year long study. The budesonide inhaler group, however, had significantly higher pre-bronchodilator PEF's indicating more open airways at periods prior to inhaler treatment. With regard to exacerbations and severity all 3 groups were similar. Patient-reported outcomes and symptom-free days were both higher in the budesonide group while the two other groups scored similarly.

Other interesting points to the study include that during exacerbations patients took the recommended budesonide or prednisone only 55% and 37%, respectively, of the times they reported symptoms severe enough to warrant either of the medicines. Quality of life scores showed no difference among the treatment groups that the authors thought might relate to the low disease burden of mild persistent asthma.

Both support and caution were offered in the editorial by Fabbri. He seemed to welcome the open debate regarding "gold standard" of continuous treatment vs. the novel plan presented by Boushey with the study providing reasonable supporting data. He notes that prior studies endorsing the use of continuous medications included smokers and children, important considerations in the clinic populations. The use of intermittent medications showed no decline in lung function- but this study lasted only a year. Fabbri cautioned careful selection of this treatment in practice lest asthma severity be underestimated and the wrong patients receive intermittent therapy.

Boushey, H. Daily versus as-needed corticosteroids for mild persistent asthma. NEJM Vol 352(15): 1519-28 (April 14, 2005).

Fabbri, L. Does mild asthma require regular treatment. NEJM Vol 352(15): 1579-81 (April 14, 2005)

Pharmacy (P&T 4/20/05) notes

Dessicated thyroid will be removed from formulary 1/1/06. Physicians must move patients to another thyroid medication by that time.

If patients are seen as part of Project Dulce, physicians can write prescriptions for Lantus or Humalog without review if the words "Project Dulce" are written on the prescription.

Thiazolidinediones are indicated for individuals who have failed Metformin as a single agent or in combination with Sulfonylureas.

Metformin SR generic has been added to formulary.

Diabenase (chlorpropamide) has been removed from formulary.

Inderal LA has been added to formulary for use to control symptoms of thyrotoxicosis.

Fosamax is available with prior authorization for the treatment of any person with osteoporosis (please provide T-score) or prophylactic therapy for individuals requiring chronic oral steroids.

Flovent HFA has added to formulary. Please start writing your prescriptions for this agent as Flovent will be phased out of supply.

For patients requiring dialysis

AmeriChoice manages the day-to-day business of the County Medical Services (CMS) Program for the County of San Diego Health and Human Services Agency. In our efforts to further improve our Treatment Authorization Request (TAR) turn-around time

for CMS patients who have been diagnosed with End Stage Renal Disease (ESRD) and require temporary or permanent AV or peritoneal dialysis access procedures, I am requesting your office staff do the following:

- Complete and have the physician sign the *End Stage Renal Disease Medical Evidence Report Medicare Entitlement* form (Form OMB NO. 0938-0046*)
- Submit Form OMB NO. 0938-0046* along with the TAR for the elective dialysis access surgical procedure.

This process will ensure a timely TAR turnaround time for your request so that you, in turn, can provide care with minimum delay. Should you or your office staff have any questions, you may contact Marimel Ovalles, RN at 858-495-1302 for further information.

*** This form may be accessed on the web- http://www.cms.hhs.gov/forms/acms2728.pdf**

Extensions for Pain Controlling Medications

For those physicians whose patients absolutely require narcotic medication refills beyond the CMS Pharmacy policy of 60 tablets per month or a one month supply, there is a solution!

You, the prescribing physician, must submit a Pharmacy Prior Authorization Request form with medical justification for ongoing, long-term narcotic therapy directly to AmeriChoice. The fax number is 858-495-1399. The request, along with the medical justification, is reviewed by the nurse case managers within one business day of receipt. If the request is approved, the nurse case manager will notify NMHC to extend the authorized narcotic medication refill period to a maximum of 6 months **or** until the end of the patient's CMS eligibility period, **whichever comes first**. The medication denial process remains unchanged. The nurse case manager will notify the prescribing physician of pharmacy approvals and denials by facsimile the day the decision is made.

Contact the AmeriChoice Medical Management staff at 858-495-1300 to ask clarifying questions about the extension of pain controlling medications. For a copy of the form, please access the CMS Formulary on the web, currently on page E. The website for the formulary is: http://www2.sdcounty.ca.gov/hhsa/documents/CMS_Formulary1_05.doc

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Back pain and clinical management

In the May 3, 2005, issue of the Annals of Internal Medicine there are two articles by Hayden and colleagues reviewing articles that have looked at exercise therapy for low back pain.

Exercise therapy is a varied grouping, but includes "general physical fitness or aerobic exercise to muscle strengthening and various types of flexibility and stretching exercises." In chronic low back pain it was shown that effective exercise programs included strengthening or trunk stabilizing exercises.

Conservative care included behavioral and manual therapies, advice to stay active and education. In chronic low back pain addition of NSAID's also provided benefit.

The results of the meta-analysis showed that in chronic low back pain there was significant benefit from exercise therapy in addition to conservative treatment while in acute low back pain, exercise therapy was no better than conservative treatment.

In the second article the type of exercise therapy contributing to the positive effect in chronic low back pain was analyzed. The result of this analysis was that among other "individually designed exercise programs" that a home exercise program with regular therapist follow-up, along with caregiver encouragement to achieve "high dosage," i.e. compliance with the exercise program, was among the effective therapies.

In the treatment of both acute and chronic low back pain it is the expectation that primary care physicians will initiate such therapy prior to referral to specialists or specialty clinics. At the initial point of contact a usual, thorough and comprehensive assessment should be made including review of systems, physical and neurologic examination looking for neurologic impairment that indicates the need for more urgent referral. Some of these indicators would include bowel or bladder dysfunction, muscle weakness or reflex abnormalities. X-rays may be done, including flexion and extension views, to assess the stability of the spinal column.

In the absence of these urgent signs and symptoms, the clinician should initiate an exercise program, often using physical therapy for home exercise instruction, with regular follow-up in the office to determine and encourage adherence. Along with this, a follow-up visit to the physical therapist is warranted to assure that exercises are being performed properly. If this treatment regimen is without benefit over 4-8 weeks, then consideration for referral and further imaging may be warranted.

In addition to low back (lumbar) pain, this same treatment approach is recommended for thoracic and cervical pain syndromes as well.

Jill Hayden, et al.; Meta-analysis: Exercise therapy for nonspecific low back pain. p. 765-775 and Systematic Review: Strategies for using exercise therapy to improve outcomes in chronic low back pain p. 776-785 *Annals of Internal Medicine Vol 142*(9).